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Seize the moment!

Moments of suspended interaction as a patient resource for introducing psychosocial problems

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Abstract

Using the methodology of conversation analysis, this study focuses on patients' disclosures of psychosocial problems during moments of suspended interaction, i.e. when the doctor is otherwise engaged. Contrary to most activities in the medical encounter, these disclosures are initiated by patients themselves. However, they are placed and designed so as not to require the doctor to respond, but rather to minimise the imposition on the doctor. Uptake, therefore, is not guaranteed. The placement of such disclosures exactly during suspended interaction displays a patient orientation to not derailing the progressivity of the consultation towards its end goal of treatment, an orientation also found by other interactional studies and shown to be related to low patient participation. The independent contribution of this study is that it enhances our understanding of the hitherto unexplored interactional barriers to the presentation of psychosocial problems in the medical consultation.

Keywords: #general practice, #conversation analysis, #psychosocial problems, #disclosure, #patient participation.

The interactional view of patient-centredness

To share power and responsibility for treatment with the patient and to adopt a biopsychosocial perspective are central principles in patient-centred health care in general practice (Mead and Bower 2002). Nevertheless, a recurrent finding in research on medical communication is that patients are generally passive when communicating with doctors (Greenfield, Kaplan & Ware 1985; Frankel 1990; Willebordse et al 2014) and that emotional distress and psychosocial issues are often overruled by the biomedical agenda (Mishler 1984; Suchman et al 1997; Salmon et al 2004). While there have been few attempts to explain the latter (though see Mishler 1984), research into the causes of patient passivity has yielded many and various types of explanations, ranging from the institutionalised authority of the doctor as a normative constraint on patients' initiative (Freidson 1970), through the sociodemographic characteristics of the patient (Eggly et al 2011), to variables of the visit itself such as length and reason for visit (Beisecker and Beisecker 1990). Relatively little attention, however, has been paid to the interaction itself and its implications for patient participation or the presentation of psychosocial problems. However, detailed and context-sensitive analysis of authentic interaction can reveal how shared norms for particular social situations, e.g. clinical encounters in primary care, are oriented to by their participants, e.g. doctors and patients, and how these common orientations shape, but also constrain, the interaction.

Aim of the study

The point of departure for the present study was to investigate one interactional method that patients were observed to employ for bringing up psychosocial problems in consultations with their general practitioner (GP). Psychosocial problems are understood as emotional distress induced by social circumstances, bad health or illness worries. Such problems are rarely introduced as the primary reason for the medical visit, but can be expressed as concerns that are subordinate or unrelated to the presented somatic problem or indirectly by way of verbal and non-verbal „cues" (Zimmerman et al 2011). The focus of the present study, however, is not the nature of these cues and concerns in themselves, but rather the way in which their presentation is managed in terms of placement in the overall structure of the consultation, namely in suspensions of interaction.

The choice of exactly this locus as a launch pad for psychosocial issues is not coincidental, and as will be argued below, appears to be closely connected with the inherent structure of primary care visits. As conversation analytic studies have established, this very structure is intimately connected with the findings of low patient participation in the medical encounter. This study thus contributes in two ways to the discussion about patient-centredness in health care, firstly by adding to our understanding of the nature of the barriers to bringing up psychosocial issues in the medical encounter, and secondly, and as a consequence of the former, by offering a small piece in the bigger puzzle of interactional explanations to low patient participation.

In order to clarify the connection between these two aspects of the doctor-patient relationship, the article starts by selectively reviewing interactional studies which together offer an endogenous explanation to low patient participation. Secondly, the data and methodology used for the study is presented, and as a prerequisite for the analyses, the concept of *adjacency pair* is introduced. Thirdly, the phenomenon under consideration, i.e. disclosures of psychosocial issues, is defined and subsequently illustrated in the analyses section, in which the common features of the phenomenon and the patient logic behind it is described. Finally, how the results contribute to the existing literature on patient participation in general and to barriers to the presentation of psychosocial problems in particular is discussed.

An interactional explanation to low patient participation

In their seminal paper, Sacks, Schegloff and Jefferson (1974) lay out the principles for turntaking in ordinary conversations. They see turntaking as the organising principle for a number of speech-exchange systems, be it ceremonial interactions, interviews, or spontaneous, everyday interactions. Everyday conversation is regarded as the default speech-exchange system, characterised by e.g. turns of talk that are of variable length and not preallocated to specific speakers. Descriptions of doctor-patient interaction applying the framework of Sacks, Schegloff and Jefferson, however, highlight how medical encounters differ from this. Mishler (1984) and Frankel (1990) both observed how the activity of questioning is almost exclusively restricted to the doctor. Mishler (1984) thus describes

how the doctors' use of biomedically focused yes/no questions and subsequent follow-up questions serve to restrict patients' communicative initiative and suppress expressions of life-world concerns. In Frankel's data (1990) less than one percent of the utterances are questions initiated by the patient. Frankel furthermore observes that patient-initiated utterances appear to have a systematic distribution sequentially, namely in boundaries between activities in the interaction (1990). Gill (1998) focuses on the organisation of patients' illness explanations, i.e. hypotheses of causes of their ailment. Generally, these are produced as extensions to answers to information-gathering questions from the doctor during history-taking. However, they are specifically *not* produced as questions, and therefore do not compel the doctor to answer. Patients, it seems, venture their illness theories so as to impose minimally on the doctor and furthermore minimise the risk of being overtly ignored. Heath (1992) and Peräkylä (1998) devote their attention to the diagnostic phase of the consultation. Both find that patients overwhelmingly limit their response to minimal acknowledgements during this activity, except in cases of uncertain or „no problem" diagnoses. Heath (1992) sees this passive behaviour as a product of the doctors' authoritarian manner in delivering the diagnosis.

Robinson (2003) reframes these interactional studies of separate medical activities by looking at the entire consultation as one coherent entity, an interactional *project*, in which both the doctor and the patient are stakeholders. Grounded in the details of the interaction, Robinson demonstrates how, in acute visits with new medical problems, both parties display their orientation towards a common objective, namely that of remedying the patient's problem. The phases that constitute the consultation are all directed towards this ultimate aim. Thus, „[...] treatment is contingent upon diagnosis, which is itself contingent upon physicians obtaining information about patients' problems, which is initially garnered from patients' presentations of their problems and subsequently from history taking and/or physical examination." (Robinson 2003, p. 47). The „pressures against patient initiated actions" (Robinson 2003, p. 51) thus, do not reside in *a priori* asymmetries of authority, but rather in a common orientation towards arriving at a treatment. Robinson's findings thus reframe, but are also supported by, the findings of the above-cited studies: The systematic distribution of patient-initiated

utterances found by Frankel thus testifies to patient orientation to a structure and progression in the consultation, and consequently to each phase and its sub-sequences as a „window of opportunity" for imparting information while not hindering the progression of the project. Likewise, patients' illness explanations (Gill 1998) are clearly associated with diagnosis, and prompting the doctor for confirmation or disconfirmation prematurely is therefore potentially derailing for the orderly progression of the project. Finally, the findings of Heath and Peräkylä that patients receive diagnoses very passively makes sense considering that diagnosis is a last step towards the ultimate goal of treatment. „No problem" diagnoses and uncertain diagnosis, on the other hand, could be heard to jeopardise the activity of treatment and for this reason evoke more involvement from the patient.

The above interactional studies thus offer an endogenous view of the observed asymmetries of communicative initiative as constructed interactively and *in situ*. The analyses below provide evidence that the presentation of psychosocial problems is also constrained by considerations for not derailing the progression of the shared project of medical problem-solving.

Data and method

The data is from a corpus of 197 video recorded consultations from the Danish general practice recorded with 10 different GPs between October 2009 and November 2010. Informed consent was obtained from each participating patient. Any materials which could identify the participants have been anonymised in the transcripts. The data is registered with the Danish Data Proctection Agency.

The method used is conversation analysis (Heritage 1984; Sidnell 2010), a microanalytic approach to authentic interaction using detailed transcripts of spoken interaction which conform to the transcription conventions developed by Jefferson (2004). A key to these conventions is provided in the Appendix. The analytic interest of conversation analysis is in demonstrating what matters to participants in a given interaction and how they display their orientation to these relevancies, both verbally and nonverbally. The end goal is to document common patterns of individual instances and thus enhance our understanding of how these instantiate underlying norms.

For the reader who is not familiar with the conversation analytic method, a concept central to the analyses will be briefly introduced, namely that of the *adjacency pair*. This concept had its genesis in the observation that particular utterances are recognizable as initiating a particular class of action and therefore as requiring a particular class of action in response (Schegloff and Sacks 1973). Thus, a greeting calls for a greeting in return, an invitation calls for an acceptance or rejection, etc. That such pairs of actions are „adjacent" does not mean that one must follow immediately after the other, but rather that the introduction of the *first pair part* creates an expectation that its *second pair part* be produced at some point in the interaction. The absence of the latter, thus, is noticeable. However, it is far from the case that all actions come in neat pairs. Many first pair parts do not *require* a particular class of action in response, but rather *makes relevant* some form of answer in the next position (Goodwin and Heritage 1990). This is also the case for the introduction of psychosocial problems investigated here.

Disclosures of psychosocial issues during suspended interaction

The phenomenon explored in this article is patients' disclosures of psychosocial issues in one particular locus of the consultation, namely during suspensions which arise because some activity temporarily pauses the progressivity of the verbal interaction about the medical problem. This typically happens when the GP is engaged with the computer or with practical tasks related to the investigation of the medical problem. The beginning of a suspension can be explicitly marked, e.g. by the GP announcing it in advance, thus accounting for their imminent interactional unavailability. Alternatively, GPs or patients can embody the upcoming of a suspension by e.g. withdrawing gaze or by shifting their body position away from the face-to-face position of regular talk in interaction (Robinson and Stivers 2001). The accomplishment of a suspension is thus interactionally achieved. In such suspensions, patients have the choice to keep silent and await the finishing of the practical task that has occasioned the suspension, and patients most often do. Characteristic for the disclosures during suspensions, however, is that they are initiated by the patients with no immediate prior occasioning in terms of questions or other response-demanding ac-

tions from the GP. Such disclosures are rare, and the instances given below were the only occurrences of the phenomenon in the data. These cases will illustrate that disclosures can range in form from direct announcements to contributions that are not in themselves disclosures, but which can serve as a launch pad for the „actual" problem, the successful addressing of which is therefore heavily dependent on the GP's uptake. The phenomenon described here thus both resembles, but also differs from, the *in situ* introductions of additional medical problems in the consultation described by Campion and Langdon (2004). Like the psychosocial disclosures described here, these are often done in connection with interactional suspensions, for which reason Campion and Langdon also refer to them as „opportunistic announcements" (ibid, p. 96). These explicitly mark the announced problem as another medical problem in its own right and therefore often work to re-start the project of medical problem-solving. The disclosures of psychosocial issues, however, are presented in a manner that makes the treatment of them *as a problem* optional for the GP, and the analyses below provide illustrations of both scenarios, i.e. of the GP validating the problem as worthy of attention and of the GP not doing so.

The Analyses

In excerpt 1, the patient presents with abdominal pain. As the GP takes the history, she also asks the patient if the pain worries her. The patient confirms this, but does not elaborate at that point. After the physical examination, the GP asks the patient to get on the scales to check for weight changes. Excerpt 1 starts when the patient has just stepped up on the scales and the GP has walked back to her desk where she is standing, looking at the computer.

Ex. 1: Colon cancer

1	*P:	Nu har jeg sko på[:,
1a		**Now I am wearing shoe[s**
2	*GP:	[ja det okay,=
2a		**[yes that's okay=**
3	*GP:	=det tror jeg oss du plejer å ha
3a		**=I think you usually have that**
4	*GP:	når du bli'r vejet har du ikk det¿
4a		**when you are being weighed don't you**

5	*P:	Jo: det har jeg.
5a		**yes I do**
6		(10.3)
		((GP walks back to desk, stands beside the desk looking at the computer))
7	*P:	Nej det bekymrer mig faktisk ¶lidt
7a		**No it actually worries me ¶a little**
		((¶GP moves gaze from computer to P on the scales))
8	*P:	fordi (0.6) min mo:r (.) hun havde det,
8a		**because my mum she had it**
9		(2.4)
10	*GP:	[ja?]
10a		**[yes]**
11	*P:	[tyk]tarm(en)
11a		**[the] colon**
12	*GP:	(hvis du lig-)
12a		**(if you jus-)**
		((Omitted sequence during which GP instructs P to reactivate the digital scales))
28	*GP:	Hvad havde din mor siger du¿
28a		**What did your mum have you say**
29	*P:	Min mor hun havde tyktarms: (0.4) kræft.
29a		**My mum she had colon (0.4) cancer**
30		(0.3)
31	*GP:	okay?
31a		**okay**
32		(1.7)
		((GP enters something on computer)
33	*GP:	Hvor læng- Er der andre end hende der har haft;
33a		**How long- Are there others than her who have had**

In line 7, the patient returns to the issue of worry, signalled by the use of „no“ (*nej*) which here marks a resumption of previous talk (Broe 2003). She announces a worry and accounts for it with an opaque remark about her mother having had „it“ (line 8). Although this turn is an elaboration on her own earlier confirmation of being worried, it is also a first pair part of an announcement which makes relevant various possible responses. During the account the GP moves her gaze from the computer to the patient and thus signals recipiency (cf.

the ¶ marks of synchronicity, line 7), but then notices that the electronic scales are not working, which occasions a short, omitted side-sequence. In line 28, the GP then proceeds to elicit a clarification of the patient's prior remark, and this occasions a sequence of questions about cancer in the patient's family. The GP thereby responds to the problem in terms of its potential medical relevance. Excerpt 1 thus demonstrates a psychosocial issue, illness worry, in relation to the medical problem under investigation, presented as a patient-initiated contribution in the form of a direct announcement and validated by the GP's uptake.

In excerpt 2, a young, single mother has come with her toddler who has been suffering from a cough on and off over the winter. The GP recommends that they put him on a treatment for asthma. When excerpt 2 starts the GP has therefore engaged with the computer to find an appointment with the asthma nurse, and in lines 1-4 she accounts for having turned to the computer. Immediately before this excerpt, however, the patient noticed that the child has had a bowel movement and that some has leaked from the diaper onto her trousers.

Ex. 2: Power drill

1	*GP:	Ska du se,
2		Jeg finder lige en tid inde hos Anne
3		hvor hu-=Så'n at- (.) at vi ka få det
4		i gang på en fornuftig måde (ikk å)
1a		**Look**
2a		**I will just find an appointment with Anne**
3a		**where sh-=So that- (.) that we can get it**
4a		**started in a sensible way (right)**
		((GP looks at computer, P looks down on CHI))
5		(1.7)
6	*P:	·hhh Men ¶nu har han så oss været
6a		**·hhh But ¶then he's also been**
		((¶ P moves gaze to GP))
7		hjemme ve' Lennart i weekenden=
8		=der ved jeg ikke lige hva (der) ryger;
7a		**over at Lennart's this weekend=**
8a		**=there I don't know exactly what he's**
9		(0.5)

10	*P:	·hh HH (i(hh)nedenbords) a::f (0.3)
11		'skellige ti[ng,
10a		**·hh HH (b(hh)eing) fed of**
11a		**'l sorts of thi[ngs**
12	*CHI:	[hrrrr hrrrrr
		((coughs))
13	*GP:	(°x[xx°)
13a		**(°x[xx°)**
14	*P:	[Jeg har fået a vide a han ha'd' ladt ham
14a		**[I have been told that he has let him**
15		lege me' en hammer å en boremaskine ( ),
15a		**play with a hammer and a power drill ( )**
16		(1.3)
		((P looks at GP, GP makes single head shake, P turns gaze down))
17	*P:	Det jeg godt [sur over.]
17a	***P:**	**I am pretty [cross about that]**
18	*GP:	[Er Lennart alen]e me'
18a	***GP:**	**[Is Lennart alon]e with**
19		ham når han er de:r;
19a		**him when he's over there**

While the GP is looking at the computer, the patient is looking at her child, and after a silence (line 5) the patient tells the GP that the child spent the weekend at his father's (lines 6-7). The immediate relevance of this is not clear until the expansion latched on to it in lines 8-11, which is formatted as an explanation for the diaper incident (cf. the „then" line 6). The GP is still engaged with the computer, but displays responsiveness (line 13). The patient thus continues, and introduces new, rather disturbing, information about the son's weekend with his father (lines 14-15). This is an independent contribution, i.e. a first pair part, which simultaneously reports an alleged instance of irresponsible behaviour, and expresses a concern. It can therefore be responded to in several ways. The GP initially receipts it with just a slight, sideways headshake while still gazing at the computer (line 16). In overlap with the patient's apparent pursuit of an assessment (line 17), the GP then responds by initiating an inquiry into the circumstances of the child's visits to his father's (lines 18-19). This inquiry continues and is terminated

when the GP offers the patient the opportunity to discuss it some other time (not shown). Excerpt 2 thus is an instance of a patient-initiated presentation of a psychosocial problem that is entirely unrelated to the medical problem. This is done by gradually approaching it through a related topic occasioned by events earlier in the interaction. In this case, the GP validates the problem as legitimately deserving of professional attention.

In excerpt 3, the patient presents with severe lower back pain and after history-taking and physical examination is given acupuncture. We enter the consultation as the GP has finished putting in the needles and has sat down at his desk and started to fill out some papers.

Ex. 3: All alone

1	*GP:	Bare prøv at: slappe af så godt som du ka',
1a		**Just try and relax as well as you can**
2	*P:	a ja.
2a		**yes yes**
3		(20.0)
		((P is lying on examination bed, GP sits at desk occupied writing))
4	*P:	Nej for havde jeg ikke haft Annemette
5		så havde jeg været helt på:'n.
4a		**No cause had I not had Annemette**
5a		**I would have been completely lost**
6		(0.8)
7	*GP:	[ja,]
7a		**[yes]**
8	*P:	[Jeg] har jo trods alt oss en hund,
8a		**[I] do after all have a dog too**
9		(0.2)
10	*GP:	Hun har hjulpet dig (.) me' å få købt
11		ind å så nogen ting,
10a		**She has helped you (.) do the shopping**
11a		**and such things**
12	*P:	Ja: å hun (0.4) hjælper mig me' å gå
13		me' (0.9) me' Fido når jeg ikk ka;
12a		**Yes and she helps me walk**
13a		**Fido when I can't**

14	*GP:	ja,
14a		**yes**
15		(1.5)
16	*P:	Det jo grimt når man slet ikk har
17		noget familie der ka hjælpe en.
16a		**It's hideous when you don't have**
17a		**any family who can help you**
18		(0.4)
19	*GP:	ja,
19a		**yes**
20		(6.0)
21	*P:	Jeg er jo mutters alene.
21a		**I am all alone**
22		(0.8)
23	*GP:	°jaer.°
23a		**yes**
24		(0.9)
25	*P:	Far han ka jo ikk hjælpe;
25a		**Dad he cannot help**
26		(0.8)
27	*P:	Tværtimod,
27a		**On the contrary**
28		(1.0)
29	*P:	Så det ham der ska ha hjælp.
29a		**It's him who needs help**
30		(0.3)
31	*GP:	ja,
31a		**yes**
32		(11.1)
33	*GP:	Ka du mærke nogen (0.3) ændring (.) allerede nu,
33a		**Do you feel any change already now**

After a long pause (line 3) the patient initiates talk by producing a first pair part, which is hearable as prefatory to a story of having gone through tough times. The patient mentions the name of a person, without whose help she would have been lost during the period of back pain. It is notable that this remark is prefaced by a „no" (cf . excerpt 1, line 7 above), which appears to mark its connection with something previously talked about (Broe 2003), although this is

not the case. As we can see from the interaction, the GP initially engages in this talk by producing a (rather absent-minded, cf. the patient's previous line 8) candidate understanding (lines 10-11). However, when the patient subsequently twists the focus of her talk, at first by complaining that she has no family who can help her (lines 16-17), and then by upgrading this to an unmitigated existential complaint (line 21), the GP withdraws his engagement and from that point produces only minimal or no responses (lines 19, 23, 26, 28, 31 and 32) and finally changes the focus back to the medical agenda (line 33). Excerpt 3, then, illustrates a patient-initiated, „stepwise escalating" disclosure of an existential problem which is apparently unrelated to the medical problem presented, and furthermore how such disclosures can also be „smothered" interactionally.

Characteristics of disclosures

In the three cases presented above, the ways in which the patients manage to disclose their distress have certain common features:

1) They occur during suspensions of the interaction and thus the doctors do not have eye contact with the patient.
2) The disclosure, or its lead-up (in excerpts 2 and 3), is marked as being resumptive of (excerpt 1, line 7, excerpt 3, line 4) or occasioned by (excerpt 2, line 6) some previous topic in the consultation.
3) The disclosures are first pair parts, in the sense of independent turns which make some form of response *relevant*, but do not *require* a particular response.

These features of the design and placement of the disclosures display important aspects of a common patient orientation. Firstly, as the disclosures are clearly patient-initiated, it is significant that the patients design them as responsive to parts of the prior conversation (see point 2). This particular feature of their design testifies to a particular constraint on patient contributions during moments where the interactional floor is empty, namely that they are not free to introduce simply any topic, but have to keep the talk within the topical limits of the medical problem that is being dealt with. Nevertheless, the problems disclosed in excerpts 2 and 3 are, in effect, not so. In both excerpts, the utterance leading up to the disclosure is

unrelated to the problem eventually disclosed, but rather seems to be a stepping stone for approaching it. Furthermore, in both cases the disclosed problem is at best peripheral to the reason for the visit, and the indirect approach thus could display an orientation to the low *medical* legitimacy of the problem disclosed (Heritage & Robinson 2006). In support of this, we may note that the disclosures of excerpts 2 and 3 are both placed after the treatment has been resolved, and the interactional project is thus complete (Robinson 2003). In contrast, the disclosure in excerpt 1 is placed in the history-gathering phase, i.e. in the very middle of the interactional project. Secondly, by way of the formatting (see point 3) and placement (see point 1) of the disclosures, the patients appear to minimise the imposition on the GPs, who can *choose* to be preoccupied, as happens in excerpt 3. The underlying logic appears to be similar to the orientation underlying the patients' design of illness explanations, namely to avoid their contribution being overtly ignored (Gill 1998). Finally, the placement of the disclosures (see point 1) demonstrates patient orientation to the overarching interactional project of solving the presented medical problem, in relation to which the disclosed trouble is - or at least is *presented as* - subordinate.

Discussion

The above findings thus agree with and contribute to prior research in several ways. As with the findings on the absence of patient-initiated utterances during specific phases of the consultation (Frankel 1990, Heath 1992, Gill 1998), they add support to there being a common orientation in both patients and doctors to the medical consultation as a highly structured, „tight" and overall monotopical construction, composed of a series of consecutive activities that presuppose each other and have treatment as their end goal (Robinson 2003). As argued by Robinson, it is this common orientation that accounts for the low degree of patient involvement when interacting with doctors. What this paper demonstrates, however, is that patients also find „loopholes" in the tight structure of this project where they can, and do, take interactional initiatives of their own accord, while clearly observing the restrictions of the common interactional project. The disclosures of emotional distress, although they may be topically unrelated, nevertheless

represent an orientation towards the common project of treating the presented problem.

In the current data set, psychosocial problems, inclusive of illness worries, are rarely presented in the problem presentation phase of the visit. This, however, is not to say that patients could not choose to introduce such problems as problems in their own right, and in some cases, they in fact do. However, the finding that patients disclose psychosocial issues during suspensions in the interaction is indicative of a finely tuned patient orientation towards the degree of medical legitimacy inherent in the problem disclosed, in other words, the extent to which the problem is seen to fall properly within the doctor's remit. The finding that patients can be seen to present this type of problems in a manner that gives the doctor ample opportunity for forgoing it, however, is a contribution to our understanding of a phenomenon which is relatively well described in the literature, but poorly understood, namely that doctors often miss or fail to address „empathic opportunities" (Suchman et al 1997) or psychosocial agendas voiced by patients (Salmon et al 2004). The data further gives rise to the hypothesis that not only patients, but also doctors calibrate the medical relevance of the disclosed distress and that this calibration can influence the likelihood of uptake. Problems that are beyond the doctor's scope of influence, e.g. loneliness, thus may be more likely candidates for „interactional smothering".

This conversation analytic contribution adds a small piece in the bigger puzzle of explanatory factors that can be conducive to patient passivity in the medical encounter. Furthermore, the article has described a method with which patients can exploit these structures to voice agendas that are otherwise hard to fit in anywhere in the consultation. This demonstrates that a context-sensitive, microanalytic approach can enhance our understanding of the underlying logic and norms of participants in a given speech situation and how this can both shape and constrain the unfolding of the interaction. The practical implications of the phenomenon described here are better left for health care professionals to extract. However, the exposure of participant orientations, which the endogenous interactional perspective affords us, is a reminder of the importance of *not* making recommendations about patient-centredness without regard for the participants themselves and their demonstrated understanding of what is relevant and significant in particular interaction contexts.

Appendix: Transcription conventions

(Adapted from Jefferson 2004)

[ ]	Overlapping speech
(.)	Micropause (less than 2 tenths of a second)
(0.4)	Pause length (tenth of seconds right of full stop, whole seconds left)
=	No break or gap between the utterances that it ends and begins
.	Falling intonation
;	Semi-falling intonation
,	Flat (continuing) intonation
?	Rising intonation
¿	Semi-rising intonation
↑	Pitch rise on following syllable
:	Prolongation of immediately preceding sound
obvious	Stressed syllable
(such)	Doubt about the word(s) being said
(x)	Indistinct syllable
((P shakes head))	Comments (about gestures etc.) in double parentheses
d(h)ead tired	Inserted laughter syllable(s)
-	Cut off (contraction of the vocal cords)
£	Smiley voice
for	Creaky voice
~	"Wobbly", i.e. cry voice
hh	One or more h's indicate outbreath
·hh	Dot before one or more h's indicate inbreath
·mfshh	Dot before anything indicates vocalising on inbreath, e.g. a sniff
°or°	Lower volume than surrounding talk
lOUd	Capital letters in words indicate higher volume
And then	Capital letter beginning a line indicate pitch reset
> <	Faster than surrounding talk
< >	Slower than surrounding talk

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